STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676436	A. Building B. Wing	10/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thrive Rehabilitation of Pearland	3406 Business Center Drive Pearland, TX 77584

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for 1 (CR#1) of 7 residents reviewed for change of condition, in that,The facility failed to consult with or establish contact with the MD or on-call medical personnel for guidance on 6/12/25 at 5:30pm, when CR#1 had a serious medical event, in which she was noted to have an altered mental status and her blood sugar was critically low. CR#1 experienced a second event 13 hours later and was noted to be unresponsive, which resulted in immediate hospitalization where she was treated for hypoglycemia and an Altered Mental Status.An Immediate Jeopardy (IJ) was identified on 10/03/2025 The IJ template was provided to the facility (administrator) on 10/3/25at12:26pm While the IJ was removed on 10/04/2025, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could expose residents to delay in treatment, worsening of condition, hospitalization, and death. Findings Include: Record review of CR#1's face sheet dated 6/10/2025 reflected a [AGE] year-old female, with an original admission date of 10/1/2003 with diagnoses of ESRD (Kidney failure), hypertension (high blood pressure), diabetes mellitus without complications (type 2) and UTI (bladder infection). Record review of CR#1's MDS dated [DATE], revealed CR#1's cognitive skills were severely impaired, and she was dependent on staff for all her needs; there was no BIMS score listed. Record review of CR#1's orders dated 6/13/2025 revealed, CR#1 was prescribed Glipizide (5mg) for diabetes mellitus without complications. Blood glucose greater than 100 on 6/11/25 and D/C on 6/13/25 at 6:42am; Gabapentin (100MG) (1 tablet by mouth 3 times a day) for diabetes mellitus without complications on 6/11/25 and D/C on 6/16/25. Record review of CR #1's baseline care plan dated 6/10/25, revealed dialysis treatment and to be educated on medication order for cardiovascular medications, anticoagulants, hypoglycemic medications/insulin. Record Review of nursing notes dated 6/12/25 at 5:30pm written by LVN A revealed, pt found lethargic during rounds, vitals assessed blood sugar monitor read low, bp 128/57, spo2 94, r 18, temp 97.5, glucagon (medicine that treats low blood sugar) administered x 1, rechecked 10 min later blood sugar 25, ems called, pt stabilized and remains on unit. rp notified. will continue to monitor. Record Review of nursing notes dated 6/13/25 at 6:07am written by LVN B revealed, Patient found lethargic, unable to arouse, vitals assessed blood sugar monitor read low, bp 120/50, spo2 91, r 10, temp 97.5, P 65 , glucagon administered x1, 911 was called, Rales to Bilateral lungs (crackling sound in both lungs), recheck sugar 3x and got a reading of 21, EMS, unable to rouse patient, patient was routed to Local hospital. Record Review of Nursing notes on 6/12/25 and 6/13/25 revealed no SBAR, no Monitoring, and/or no assessment of CR#1's level of consciousness or any follow-up notes by nursing between 6/12/25 at 7:17pm when the last blood pressure was taken and 6/13/25 at 6:07am when CR#1 was found in her bed non-responsive.Record Review of Facility's last vitals taken for CR#1 reflected:6/12/2025 Blood Sugar taken at 5:30pm_25 6/12/2025 Blood Pressure taken at 7:17pm 120/72 6/12/2025 Pulse taken at 5:30pm 59 bpm 6/13/2025 O2 stats taken at 1:02am 98.0% 6/12/2025 Temp taken at 7:10pm 97.8F Record Review of Nursing notes on 6/12/25 and 6/13/25 revealed no SBAR, Monitoring, assessing or follow-up notes by nursing. Record Review of the EMS run report dated 6/13/25 revealed, the FD responded to a call from the NF of an unconscious person. The report indicated the chief complaint was low BLG. EMS arrived to find the patient sitting up in bed, snoring. The patient was unresponsive with a GS of six. EMS assessed CR#1's vital signs which revealed, CR#1 was unresponsive at 5:56 AM with a blood pressure of 99/50, pulse 60 R, respiratory 14 R, oxygen 96%, blood sugar low did not register. The RN reported CR#1 was found with a low blood level of 21 and was administered glucagon and CR#1 did not respond, and 911 was called. The RN reported CR#1 had a hypoglycemic episode (low blood sugar) last night, was given glucagon, and treated with IV glucose by EMS and not transported to the ER. Record review of the Local Hospital B notes dated 6/13/25 revealed, CR#1 transferred to ER due to AMS and hypoglycemia. She was initially admitted to IMU (a step down or progressive care) and started on cefepime (treat bacteria) and Vanco (treat infection) but was transferred to ICU (highest level of care for critically ill patients) overnight due to worsening hypotension (low blood pressure) requiring vasopressors (used to treat dangerously low blood pressure). During a telephone interview on 10/1/25 at 2:10pm with LVN A she stated on 6/12/25, CNA A reported CR#1 was not looking well and didn't eat her lunch or dinner. LVN

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (CR#1) of 7 residents reviewed for quality of care. The facility failed to send CR#1 to the hospital when her blood sugar was extremely low, despite EMS being called before and arriving 13 hours before her eventual transport to the local hospital. The facility failed to monitor CR#1's blood sugar for approximately 13 hours after it was documented as critically low. This lapse led to a second hypoglycemic episode during which CR#1 was found unresponsive and required emergency medical care. An Immediate Jeopardy (IJ) was identified on 10/03/2025 The IJ template was provided to the facility (administrator) on 10/3/25at12:26pm While the IJ was removed on 10/04/2025, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for possible serious injuries, harm and death. Findings Include: Record review of CR#1's face sheet dated 6/10/2025 reflected a [AGE] year-old female, with an original admission date of 10/1/2003 with diagnoses of ESRD (Kidney failure), hypertension (high blood pressure), diabetes mellitus without complications (type 2) and UTI (bladder infection). Record review of CR#1's MDS dated [DATE], revealed CR#1's cognitive skills were severely impaired, and she was dependent on staff for all her needs; there was no BIMS score listed. Record review of CR#1's orders dated 6/13/2025 revealed, CR#1 was prescribed Glipizide (5mg) for diabetes mellitus without complications. Blood glucose greater than 100 on 6/11/25 and D/C on 6/13/25 at 6:42am; Gabapentin (100MG) (1 tablet by mouth 3 times a day) for diabetes mellitus without complications on 6/11/25 and D/C on 6/16/25.Record review of CR #1's baseline care plan dated 6/10/25, revealed hypoglycemic medications. Record Review of nursing notes dated 6/12/25 at 5:30pm written by LVN A revealed, pt found lethargic during rounds, vitals assessed blood sugar monitor read low, bp 128/57, spo2 94, r 18, temp 97.5, glucagon (medicine that treats low blood sugar) administered x 1, rechecked 10 min later blood sugar 25, ems called, pt stabilized and remains on unit. rp notified. will continue to monitor. Record Review of nursing notes dated 6/13/25 at 6:07am written by LVN B revealed, Patient found lethargic, unable to arouse, vitals assessed blood sugar monitor read low, bp 120/50, spo2 91, r 10, temp 97.5, P 65 , glucagon administered x1, 911 was called, Rales to Bilateral lungs (crackling sound in both lungs), recheck sugar 3x and got a reading of 21, EMS, unable to rouse patient, patient was routed to Local hospital. 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The RN reported CR#1 was found with a low blood level of 21 and was administered glucagon and CR#1 did not respond, and 911 was called. The RN reported CR#1 had a hypoglycemic episode (low blood sugar) last night, was given glucagon, and treated with IV glucose by EMS and not transported to the ER. Record review of the Local Hospital B notes dated 6/13/25 revealed, CR#1 transferred to ER due to AMS and hypoglycemia. She was initially admitted to IMU (a step down or progressive care) and started on cefepime (treat bacteria) and Vanco (treat infection) but was transferred to ICU (highest level of care for critically ill patients) overnight due to worsening hypotension (low blood pressure) requiring vasopressors (used to treat dangerously low blood pressure). Record review of facility Diabetic Management Policy dated January 2021 revealed the following: HYPOGLYCEMIA PROTOCOLMild reactions: For a mild reaction when the resident is awake but signs or symptoms of low blood sugar or has a blood sugar level less than 70 mg/dl: Rule of 15 Give 1/2 cup of juice (apple or orange juice [for Renal patients, avoid orange juice Give a 15 gram dose of glucose gel (read labels) or glucose tablets. Brands vary. Wait 15 minutes and recheck the blood sugar. If the resident continues to have low blood sugar or has a blood sugar level below 70 mg/dl. Repeat the treatment. Recheck the blood sugar in 15